

# Heartsink patients: a study of their general practitioners

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## SUMMARY

**Background.** A number of attempts have been made to investigate the heartsink, difficult, dysphoric or problem patient. Most studies have emphasized the role which the patient plays in evoking despair, anger and frustration in the doctor. However, one doctor's list of difficult patients may not necessarily be the same as another's.

**Aim.** A study was undertaken to determine if the individual characteristics of general practitioners are associated with the number of heartsink patients they report on their patient lists.

**Method.** Sixty out of 137 urban general practitioners drawn at random from the Sheffield Family Health Services Authority list were surveyed by structured interview and questionnaires in 1990. Outcome measures were interview data and scores on the 12-item general health questionnaire, Warr-Cook-Wall job satisfaction scale and the Bortner personality profile measure.

**Results.** Sixty per cent of the variance in the number of heartsink patients that general practitioners reported on their lists could be accounted for by the following four explanatory variables: greater perceived workload; lower job satisfaction; lack of training in counselling and/or communication skills; and lack of appropriate postgraduate qualifications. No other variables considered could account for the variance in the number of heartsink patients reported by general practitioners.

**Conclusion.** The individual characteristics of doctors are associated with the number of heartsink patients reported by general practitioners. To reduce the number of such patients experienced, it may be necessary for general practitioners to reduce their workload and increase their job satisfaction and their level of relevant postgraduate training.

**Keywords:** difficult patients; doctors' attitude; workload; job satisfaction; postgraduate education.

## Introduction

'There are patients in every practice who give the doctor and staff a feeling of "heartsink" every time they consult. They evoke an overwhelming mixture of exasperation, defeat and sometimes plain dislike that causes the heart to sink when they consult.'

O'Dowd<sup>1</sup>

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THERE have been various attempts in the literature to investigate the heartsink, difficult, dysphoric or problem patient.<sup>1-6</sup> O'Dowd, for example, reported heartsink patients as a disparate group of individuals, often with serious medical problems, whose only common thread seemed to be the distress they caused their doctor and the practice.<sup>1</sup> Others have also emphasized the role which patients play in evoking 'despair, anger and frustration' in their doctors.<sup>6</sup> Groves attempted to classify patients whom he described as hateful on the basis of feelings evoked by the patient in the doctor.<sup>2</sup> To deal with each category of patient he suggested cognitive and behavioural changes in the doctor to use during consultations with such patients. Ellis, in describing the dysphoric patient, also suggested that cognitive and behavioural changes in the doctor can transform the doctor's feelings of dysphoria associated with these patients into a happy experience.<sup>5</sup> Gerrard and Riddell reported that one doctor's list of difficult patients is not the same as another's and this reflects the needs and personalities of different doctors.<sup>6</sup>

By definition, the doctor identifies who is or is not a problem or heartsink patient. A study was therefore undertaken to examine to what extent the individual characteristics of doctors contribute to a diagnosis of a heartsink patient.

## Method

The study design was a survey of urban general practitioners by structured interview and administered questionnaires. A random sample of 137 general practitioners from the Sheffield Family Health Services Authority list (40% of the total) were invited by letter to participate in a study of heartsink patients. Respondents were interviewed by N M, usually at the practice premises during the day but occasionally at home in the evening.

The doctor was asked initially to complete three questionnaires: the 12-item general health questionnaire, as an indicator of mental well-being,<sup>7</sup> the Warr-Cook-Wall job satisfaction questionnaire<sup>8</sup> and the Bortner personality profile measure.<sup>9</sup>

The general health questionnaire is a self-administered screening instrument which identifies two main classes of problem: inability to carry out one's normal healthy functions and the appearance of new phenomena of a distressing nature. The emphasis is on changes in condition so that the items compare the present state with the person's normal situation. A cut-off point of two/three on the 12-item version has been shown to identify correctly 82% of psychiatric cases.<sup>10</sup> A total score may be formed by summing the responses to the 12-items, with a high score indicating worse mental health than usual. The general health questionnaire is one of the most thoroughly tested health questionnaires, with high reliability and validity.<sup>7</sup>

The Warr-Cook-Wall job satisfaction scale provides a short, reliable and valid measure of job satisfaction.<sup>8</sup> It is easy to use, comprising 15 items with a seven-point Likert scale rating for each item, such as 'physical working conditions', 'your colleagues and fellow workers' and 'freedom to choose your own method of working'. It was modified for use in general practice according to Cooper and colleagues.<sup>11</sup>

Type A pattern of behaviour has, over the years, been accepted as being associated with cardiovascular disease and stress related illness, and the Bortner type A questionnaire may be used as a valid and reliable indicator of such behaviour.<sup>9</sup> Each of its 14 rat-

ing scales is composed of pairs of phrases, such as 'tries to do many things at once' and 'takes things one at a time', to represent two kinds of contrasting behaviour with one of the dimensions indicating type A and the other type B behaviour. According to the subject's own self-estimate, higher scores represent more type A characteristics.

The structured interview which followed the completion of the questionnaires focused on the sociodemographic details of the doctor and practice, the usual workload of the general practitioner and his/her professional experience. Usual workload was indicated by the number of sessions per week worked in the practice, the number of consultations per surgery, the length of appointments, the number of home visits per day and whether the doctor felt him/herself to be busier than usual. Professional experience was indicated by postgraduate qualifications, any formal training in communication and/or counselling skills at any point in the doctor's career, and number of years in practice. The last section of the interview schedule elicited qualitative data on the general practitioner's definition of the heartsink patient: 'what does the term "heartsink patient" mean to you?'.

Qualitative data were analysed using a grounded theory approach whereby there were no preset criteria, and categories were derived entirely from the raw data. The quantitative data were analysed by stepwise regression analysis using SPSS.

## Results

### *Doctors and their practices*

Data were collected from January to December 1990. Sixty of the 137 general practitioners invited (44%) agreed to participate, of whom 39 were men and 21 were women, equivalent to the overall sex ratio of general practitioners in Sheffield. Although a greater proportion of the non-responding general practitioners were men and the mean age of both men and women non-respondents was greater than that of respondents, these differences were not statistically significant.

The mean number of partners per practice was three and the median number of patients per practice was 4500 (range 1000–8500). A large majority of doctors (95%) did at least one 'outside session' per week, and 88% were in full-time practice (26 hours per week). The median number of consultations per surgery for each doctor was 16 (range 8–40) with a median appointment length of seven minutes. The median number of home visits per day was four.

The number of years since qualification ranged from five to 38, and 40 doctors (67%) had received vocational training. Of the doctors 63% held postgraduate qualifications. Formal training in either counselling or communication skills had been received by 32% of doctors, and training in both had been received by 37%.

### *General health questionnaire scores*

Completed questionnaires were received from all 60 general practitioners and the overall mean score was 12 (scoring 0–1–2–3). There were no doctors whose score was suggestive of psychological disturbance, using a cut-off of two/three (that is, a score greater than or equal to 24). However, 10 doctors (17%) did have a score greater than or equal to 18 (cut-off of one/two). Although men were over-represented in this group, there was no significant difference in mean age or sex distribution above or below this score.

### *Job satisfaction scale scores*

All 60 general practitioners returned completed questionnaires. The mean total score was 49 (standard deviation (SD) eight). Although women general practitioners had a slightly higher total

score (50, SD eight) than men (48, SD eight) this difference was not significant. The highest levels of satisfaction were seen in working with colleagues and fellow workers and the amount of responsibility and variety in the job. The lowest levels of satisfaction were seen with hours of work, rates of pay and recognition for good work.

### *Personality profile questionnaire scores*

All participating general practitioners completed questionnaires. The mean score was 181, approximating to that for type B rather than type A behaviour. The greatest manifestations of self-reported type A behaviour among the general practitioners were seen on the items of: few interests outside work, emphatic in speech, and anticipation of what others were going to say.

### *Heartsink patients*

Estimates of how many heartsink patients doctors had on their list ranged from one to 50 (fewer than 1% to up to 3% of their list) with a median of six per doctor. No doctor said they had no experience of heartsink patients. The range of one to 50 suggested the variable should be treated as continuous for the statistical analysis.

Definitions of heartsink patients fell into two main categories. The most commonly elicited definition was patients with whom doctors felt impotent in the sense of an angry helplessness (36 doctors, 60%). The other 24 doctors (40%) specified particular types of patients whom they considered to be heartsink patients, for example, patients with multiple symptoms (seven doctors), patients with psychiatric problems (three), patients with whom it was difficult to communicate (three), patients who were considered to be hypochondriacs (three), and frequent attenders (two doctors).

Stepwise regression analysis was used to assess which of a number of variables were statistically significant in explaining the difference in the number of heartsink patients reported by doctors. The dependent variable was defined as the number of heartsink patients reported by doctors. The independent variables were: scores on the general health questionnaire, job satisfaction scale and personality profile questionnaire; perceived workload; training in counselling and communication skills; postgraduate qualifications; number of consultations per surgery, sessions per week, visits per day and years in practice; and length of appointments.

Those variables found to be statistically significant are shown in Table 1. Sixty per cent of the difference in the number of heartsink patients reported by doctors could be explained by perceived workload, level of job satisfaction, training in communication and/or counselling skills, and relevant postgraduate training.

**Table 1.** Results of multivariate (stepwise regression) analysis showing those variables found to be significant in explaining the variance in the number of heartsink patients reported by doctors.

Variable	Regression coefficient (SE)
Less than usual workload	1.58 (3.10)
More than usual workload	15.48 (2.60)
Job satisfaction	-0.38 (0.12)
Counselling and communication skills training	-7.55 (2.33)
Counselling or communication skills training	-6.92 (2.75)
Postgraduate training	-6.53 (2.04)
Constant	33.20 (6.13)

SE = standard error. Regression equation  $R^2 = 0.60$ .

**Workload.** Doctors were asked whether the number of patients they had seen in the preceding two weeks was fewer than, the same as, or more than usual. There was a highly significant difference in the number of heartsink patients these three groups of doctors reported: those seeing more patients than usual reporting seeing three times as many heartsink patients as those seeing the same or fewer patients than usual (analysis of variance  $P<0.001$ , Table 2).

**Job satisfaction.** It was found that the lower the score on the job satisfaction questionnaire the more heartsink patients a doctor reported at interview (Pearson correlation coefficient  $r = -0.34$ ,  $P<0.01$ ).

**Counselling and communication skills training.** Doctors were divided into three categories: those who had received no training, those who had received either counselling or communication skills training at any point in their career, and those who had received training in both counselling and communication skills. Those who had received no training in communication or counselling skills reported having twice as many heartsink patients on their lists as those who had received formal training in at least one of these subjects (analysis of variance  $P<0.05$ , Table 3).

**Postgraduate qualifications.** Postgraduate qualifications considered likely to be relevant to the problem of heartsink patients were membership or fellowship of the Royal College of General Practitioners, membership of the Royal College of Physicians and a diploma in psychiatric medicine. There was a highly significant difference in the number of heartsink patients reported by the 38 doctors with at least one relevant postgraduate qualification and the 22 without (8.6 versus 14.0, respectively, analysis of variance  $P<0.01$ ).

None of the other variables could account for the variance in the number of heartsink patients reported by the general practitioners. The distribution of the other variables was normal. A normal probability plot of the standardized residuals was very close to a straight line.

**Table 2.** Doctors' perceived workload, and number of heartsink patients reported to be on doctors' lists.

Workload	Mean no. (SD) of heartsink patients reported by GPs
More than usual ( $n = 11$ )	24.5 (15.2)***
Same as usual ( $n = 40$ )	8.2 (7.2)
Less than usual ( $n = 7$ )	8.0 (5.6)

SD = standard deviation.  $n$  = number of doctors in group (data missing for two doctors).\*\*\*  $P<0.001$ .

**Table 3.** Doctors' reported counselling and/or communication skills training and number of heartsink patients reported to be on doctors' lists.

Training	Mean no. (SD) of heartsink patients reported by GPs
No training ( $n = 32$ )	14.3 (13.1)*
Counselling and communication skills training ( $n = 15$ )	7.9 (7.4)
Counselling or communication skills training ( $n = 11$ )	6.7 (4.0)

SD = standard deviation.  $n$  = number of doctors in group (data missing for two doctors).\*  $P<0.05$ .

## Discussion

Researchers of much of the published literature have focused on the problem or heartsink patient as the cause of the difficulty experienced by the doctor. Few have examined the doctor's own contribution to this experience. One exception is Illingworth who suggested that irritation with patients may arise from the doctor's own intolerance, impatience, fatigue, hunger or pressure of work.<sup>12</sup> Crutcher and Bass were able to link the professional experience of the doctor with the frequency of troubling patient encounters — the greater the doctor's experience, the fewer such encounters were reported.<sup>13</sup> Other authors found that a group of doctors most disliked patients with psychiatric symptoms and concluded that this dislike could be used as a diagnostic tool for psychiatric illness.<sup>14</sup> They did not, however, consider the doctor's contribution to this dislike.

Corney and colleagues identified three principal themes common to doctors in association with the difficult patient.<sup>15</sup> The first was a lack of control grounded in the doctor's frustration and the second was the feeling that stalemate with the patient had been reached. There was also a fear of opening Pandora's box and being overwhelmed with problems. These authors concluded that one of the first steps in managing difficult patients is to recognize, acknowledge and accept the negative emotions associated with these patients as natural and reasonable. Balint tried to get doctors to look at their own feelings in relation to their patients and one of the results of his work has been to avoid describing the characteristics of the patient as the sole cause of the difficulties the doctor encounters.<sup>16</sup>

The present study has identified four explanatory variables which are associated with the number of heartsink patients that general practitioners experience. The difference in the number of heartsink patients reported could not be accounted for by the individual characteristics of the patients<sup>17</sup> who were broadly defined by the doctors as those with whom they felt impotent in the sense of experiencing an angry helplessness, or particular types of patient.

The greater a doctor's perceived workload and job dissatisfaction, the more heartsink patients he or she is likely to report. The new contract for general practitioners was introduced in 1990 during which time the fieldwork for this study was completed. This contract has been associated with increased stress, reduced job satisfaction and poorer mental health among general practitioners.<sup>18</sup> Objective measures of workload have shown an increase in general medical services work<sup>19</sup> and it is likely that the level of perceived stress of general practitioners was raised during the study. However, the implication is that if general practitioners wish to try to reduce the number of heartsink patients they experience, their level of perceived stress needs to be reduced by, for example, lessening or reorganizing workload and increasing job satisfaction. There may also be a need for better training in organizational skills and stress management techniques for general practitioners which could be taught at both undergraduate and postgraduate levels.

A further implication of this study is the possible need for more training in counselling and/or communication skills. The concept of counselling integrates many of the great themes of general practice.<sup>20</sup> It is a natural approach for generalists who deal with a wide range of personal problems and a logical philosophy for those primarily interested in people rather than diseases. Counselling services are now widespread in general practice, although a high proportion of counsellors lack qualifications and many may be referred problems outside their knowledge.<sup>21</sup> Training in counselling skills might enable general practitioners not only to make informed choices in the selection of counsellors and more appropriate referrals to them but also to reduce the

number of heartsink patients that they experience and their levels of perceived stress.

Learning good communication skills is not just about becoming a more understanding and approachable doctor<sup>22</sup> but it may also reduce the number of heartsink patients experienced by an individual general practitioner. Only relatively recently have formal attempts been made to teach communication skills to undergraduates in the United Kingdom. Learning such skills can help both the patient and the doctor.

Having a relevant postgraduate qualification was also associated with doctors reporting fewer heartsink patients. This observation supports the importance of continuing education of general practitioners towards such qualifications as the MRCGP. There are, for example, specific management strategies for patients with medically unexplained symptoms,<sup>23</sup> somatizers<sup>24</sup> and hypochondriacs,<sup>25</sup> and studying for appropriate higher qualifications gives an opportunity to learn these strategies.

In conclusion, it is particularly interesting to note that a subjective impression of how busy doctors perceive themselves to be influences the perception of the number of heartsink patients who consult. It may be that the doctors who experience more heartsink patients have a greater need for control as a result of increased perceived stress levels. Being in control of one's work is an important element in reducing perceived stress. Defining a patient who does not play by the rules of the doctor-patient encounter as a heartsink patient may therefore be in itself a coping strategy for doctors to reduce their level of stress since the need for control may thereby be reduced. If a patient can be labelled as a heartsink patient, doctors may not feel the need for control so strongly nor feel as responsible for the patient. More importantly, doctors do not then need to confront their own negative emotions aroused when such patients consult. An approach therefore which highlighted the need for doctors to find a solution to their own difficulties with individual patients would avoid blaming the patient for the problem and encourage the development of alternative management strategies.

Finally, in a review of the diagnosis and management of problem patients in general practice, Cohen concluded that 'further examination of how doctors deal with problem patients may provide insight into the nature of all consultations'.<sup>26</sup> The present study has focused attention on the contribution of the doctor to the troubling patient encounter.

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## MRCGP EXAMINATION

The dates and venues for the October/December 1995 diet of the MRCGP examination are as follows:

**Written papers:** Tuesday 24 October 1995 at centres in London, Manchester, Glasgow, Edinburgh, Newcastle, Cardiff, Belfast, Dublin, Liverpool, Ripon, Birmingham, Bristol, Sennelager and Riyadh.

**Oral examinations:** In Edinburgh on Monday 4 and Tuesday 5 December. In London on Wednesday 6, Thursday 7, Friday 8, Saturday 9 and Monday 11 December.

The closing date for the receipt of completed applications is **Friday 1 September 1995**.

MRCGP is an additional registrable qualification and provides evidence of competence in child health surveillance for accreditation.

Further information and application forms are available from:

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